

FOR RELEASE

UPON DELIVERY

CURRENT TRENDS IN DEALING WITH MENTAL ILLNESS - ARE WE ON THE RIGHT TRACK?

Albert Deutsch Memorial Lecture

93rd Annual Forum, National Conference on Social Welfare

11:15 AM, Wednesday, June 1, 1966

Conrad Hilton Hotel, Chicago, Ill.

by

MIKE GORMAN, Washington, D. C.

Executive Director, NATIONAL COMMITTEE AGAINST MENTAL ILLNESS  
Fellow, AMERICAN PSYCHIATRIC ASSOCIATION (Hon.)  
Fellow, AMERICAN PUBLIC HEALTH ASSOCIATION

I regard it as a singular honor -- one of the treasured assignments of a lifetime to have been chosen to deliver this lecture honoring the memory and noble works of my fellow journalist and beloved friend, Albert Deutsch.

In preparing for this charge, I read or re-read many of the earlier Deutsch articles which appeared in professional journals in the 1930's and the 1940's before he had achieved a wide lay audience. I was struck again by the catholicity of his approach -- the truly enormous reach of his heart and his pen in an age when the pursuit of social welfare was not exactly in full flower. He wrote topically of matters of slowly emerging public concern -- the aged, the unemployed, the dependent child, the delinquent and, yes, even the misunderstood policeman on the beat. But he wrote with even greater penetration of the deep-seated welfare goals of a democratic society, and of how the various helping professions might work together toward their consummation if only they would take leave of their jurisdictional rigidities and subdue some of their status-seeking manipulations.

A constant champion of the profession of social work, he staked out an ever-widening claim for its employment in ameliorating the manifest injustices of society. In "The Convergence of Social Work and Psychiatry", written in 1940, he reminded us of the pivotal role of the social worker in the latter half of the 19th century in reaching out to the indigent insane in poorhouses which confined far more of these unfortunates than did the isolated mental hospitals. Paying tribute to that gallant band of social workers who took a leading part in improving the conditions of the mentally ill and in establishing after-care committees for them in hostile communities, he wrote in measured tones that "while psychiatry has offered the social worker an insight into individual personality, social workers in turn have repaid the debt by supplying the psychiatrists with an understanding of the cultural conditioning of personality."

Of course, his great classic was "The Mentally Ill in America", published in 1937. In one monumental sweep of inspired sociological research, this alumnus of the harsh poverty of the lower East Side of New York, who had never finished high school, brought into the mainstream of our social concern the agonizing history and the current plight of those legions of people who were sorely beset and troubled of mind. The successor volume, "The Shame of the States", (1948) was a more detailed expose' -- ward by ward and heartbreak by heartbreak -- of how the states were neglecting the mentally ill. A persistent Deutsch theme runs as an undercurrent through both volumes -- the imperative need for medicine, social welfare and the public at large to join forces against the twin conspiracies of silence and distance which had kept the victims of mental illness in thrall on this bright continent for almost two centuries.

It was a long, hard, fiercely-contested battle. The large mental hospitals -- monasteries of the mad -- dominated the psychiatric landscape in a most oppressive manner. Many superintendents -- self-anointed Keepers of the Keys -- rattled them in defiance at those few progressive spirits trying to smuggle a breath of the community beyond the feudal walls. An English psychiatrist, after visiting some of our intimate hospitals in the 10,000-bed range, described them as "like Victorian castles washed out by the sea and deposited on remote sandbanks."

Because they were not intensive treatment facilities -- because their overseers were arrogantly indifferent to the social welfare reforms sweeping across other parts of the body politic after World War II -- the seemingly inevitable yearly increase in the resident census of these institutions continued, and even accelerated. In the period from 1945 to 1955 alone, 130,000 additional mental patients were jammed into the already over-crowded wards of our state hospitals.

At the high point of this dreadful exodus, a few influential voices were raised in protest.

In 1953, the Expert Committee on Mental Health of the World Health Organization predicted that "many countries will be burdened for a long time to come with large, obsolete hospitals built years ago to fit a conception of the role of the mental hospital which is now completely rejected." Its report argued that no psychiatric hospital should exceed 1,000 beds, with the optimum size somewhere between 250 and 400 beds.

In that same year, Dr. Kenneth Appel, President of the American Psychiatric Association and a native of that city in which the Declaration of Independence was composed and the Constitution adopted, sounded the trumpet blast for a new revolution. Noting that

the traditional policy of herding mental patients into massive human warehouses was both therapeutically and morally bankrupt, he called for a fresh, anthropological look at the manner in which we were handling the mentally ill on these shores.

His eloquent plea led to the creation of a Joint Commission on Mental Illness and Health, empowered by the Congress to examine the existing state of affairs and come up with alternatives to a social institution which was no longer meeting even the most elementary needs of its beleaguered clients.

The Commission labored for six years; the anguished cries of the threatened professional jurisdictions could be heard far and wide, but the final report sounded the death knell of the isolated cities of the mad. President Kennedy embraced the major principles of the Commission report; in his historic 1963 mental health message to the Congress, he called for a network of community mental health centers designed to replace eventually the backwater, insulated institutions of the past.

The care and treatment of the mentally ill in the heart of the community is not exactly new. One can go back to Gheel, Belgium in the 11th century -- and possibly before that -- to find examples of communities which accepted and housed the mentally ill. In the 20th century a remarkable Dutch psychiatrist, Dr. Arne Querido, began in 1930 to develop regional psychiatric services throughout the city of Amsterdam as a viable replacement for the large hospital. In a retrospective look at the Amsterdam experiment now in its 35th year, Dr. Querido wrote:

"Any removal of a mentally disturbed patient from his social background implies the sidestepping of the nucleus of the problem... I should like to defend the thesis that, in the last analysis, the cure or the adaptation of the mentally disturbed can only be established in society and that a successful stay in society is the only real test of any therapeutic endeavor."

The unique aspects of the American experiment, as exemplified in both 1963 and 1965 federal legislation and in comparable state and local action, are its clear repudiation of a deeply entrenched custodial system and its forthright declaration of a national policy emphasizing joint federal, state and local efforts to handle mental illness in the community wherever possible.

In simple terms, it is our contention that the sequestering of the mentally ill through most of our history prevented them from drawing upon the very personnel and social agency resources which could have bolstered their ability to remain in society. In the mental health center concept, we stress flexibility and continuity of services much more than the building of a discrete physical facility. We want to be part of the mix which includes general hospitals, social welfare services, the schools, the courts and the private sector of medicine. In a reversal of past practices, we are looking for specific strengths in the patient, his family, his neighbors and his job situation which can keep him out of the hospital, as opposed to the assiduous search for diagnostic symptoms to prove that he must be hospitalized to protect the populace from him.

We believe that a number of trends, which developed so imperceptibly over the past twenty years that they have received little attention in the sociological literature, are establishing solid foundations for the new wave of community psychiatry.

For example, the so-called "inevitable" annual rise in mental patients confined in state hospitals has been arrested. Over the past decade, there has been an historic, unprecedented drop of 83,000 patients resident in these facilities. In 1965, just over four million Americans were treated for mental illness; of this number, only one in five was treated in a state institution. Compare this with the situation just two decades ago when these same institutions handled three out of every four mental patients.

The general hospitals of this nation, one almost totally off limits to the mentally afflicted, treated and discharged almost 600,000 psychiatric patients in 1965. The approximately one thousand hospitals which either have separate psychiatric units, or treat psychiatric patients on their medical wards, last year discharged more than twice as many mental patients as did state and county mental hospitals. Furthermore, part-time hospitalization, which possesses the advantage of retaining the identification of the patient with his family and other anchor points of social living, has increased remarkably over the past decade -- there are now 175 day-night hospital programs in operation in all parts of the land, and many more on the drawing board.

Local government, which for almost two hundred years dumped its unwanted mentally ill upon the doorsteps of state institutions, is now assuming a growing proportion of the burden of their care. Twenty-six states have now formalized this shared responsibility in community mental health laws which provide state and local matching monies in support of augmented psychiatric services.

A major dividend of this penetration into the community is our increasing ability to attract skilled personnel to work with these patients. The conventional remote mental institution, even under the most enlightened management, found it almost impossible to recruit psychiatric personnel willing to immerse themselves in a massive warren whose patient load was forbidding, and whose ties to professional stimulation and enrichment were tenuous at best. As a result, foreign born physicians comprise more than 50% of the total complement of doctors in a number of our state mental hospital systems, and shortages of registered nurses, psychologists and social workers are legendary and almost too painful to contemplate.

As we move out of the cloister, we find that we not only attract a significant number of health professionals -- many of whom are willing to devote a portion, if not their full time, to these tasks -- but we have opened the gates to both new and previously unused personnel resources in the community. Realizing that most people in need of psychiatric care are individuals who have not had any really warm, close, interpersonal relationships, we are developing a whole host of training programs for people who care about, and can care, for distressed people -- community mental health workers, child care aides, teacher-counsellors, teacher-moms, and the like.

A significant segment of the leadership of American psychiatry is convinced that the hallowed clinical model of the practitioner and the patient locked in suffocating transference is insufficient for the broader challenges implicit in helping large blocks of our people find a degree of adjustment and identity in this very complex society. Psychiatry is beginning to face up to the fact that its standard methodology and entrenched theoretical orientations do not equip it to meet the demands for psychological and social help from the poor, the underachieving in our schools, the frustrated among our blue collar workers, the claustrophobic residents in our crowded cities, and so on. As I told the American Psychiatric Association Convention just a year ago:

"Many of its most thoughtful leaders are giving increasing thought to the new role which psychiatry must play in the next several decades, in not only broadening its own parochial training, but in joining with other behavioral disciplines on an equal footing in establishing training programs for the thousands upon thousands of new mental health workers we will need if we are to achieve the goals which President Kennedy proclaimed in his historic 1963 mental health message."

We are also making considerable headway in opening up avenues for the payment of the costs of psychiatric care. In the long run, this may be the most revolutionary of all recent trends affecting the mentally ill.

Until quite recently the resistances to coverage of mental illness, either through government social insurance or through private carriers, were fierce and formidable. For example, leading spokesmen for Blue Cross and for commercial insurance companies expressed annoyance that we should be seeking coverage equal to that given the physically ill when it was so easy to "send them away for a dollar a day". As Helen Avnet has noted in her book, "Psychiatric Insurance":

"Mental illness was traditionally a responsibility of the government; along with tuberculosis, workman's compensation cases and care provided by veterans' facilities, it was classified as 'otherwise covered' and automatically excluded from most medical insurance policies."

Even the very liberal people who drafted the Wagner-Murray-Dingell National Health Insurance bill reflected these aboriginal prejudices when they excluded mental illness from the broad spectrum of its intended coverage. No wonder, then, that public officials bracketed the mentally ill under the eleemosynary functions of government -- a characterization right out of Charles Dickens.

The pervasive nature of this financial exclusion has seldom been properly appreciated as a prime cause in preventing mental illness from being viewed as a rightful concern of general hospitals, social agencies and other resources of the health and welfare sector. In fact, the stigma surrounding mental illness drew much of its staying power from the widespread assumption that opening the doors to its victims would invite financial ruin for any organization. Walter J. McNerney, the President of the Blue Cross Association, has referred very frankly to the lack of purchasing power of mental patients as having had long-term adverse effects, not only upon their treatment, but upon the recruitment of health manpower into what was always described as a most penurious field.

The biggest breakthrough in the reversal of these discriminatory practices has been the inclusion of the mentally ill under several important sections of the 1965 Medicare



legislation. The extension of general hospital coverage to all mentally ill over 65 years of age will, I am confident, have the most profound effect upon the overall attitude of these hospitals toward the mentally ill. The inclusion of outpatient psychiatric care for these patients -- although limited by a yearly dollar ceiling -- is of crucial importance because it gives them the very purchasing power with which to open new treatment doors in the community.

Over the long run, the provisions of Title 19 of the Medicare legislation may prove of equal significance. State plans have the option of not only covering the medically indigent psychiatric patient over the age of 65, but of providing a wide variety of general hospital and alternate community services for those under 65 years of age.

There has been an exciting corollary development in the new militancy of American labor regarding the provision of psychiatric services for its membership. As the 5th Constitutional Convention of the AFL-CIO noted in a policy statement in November, 1963:

"The incidence of mental illness among low income groups is the highest in the nation. Existing methods of reaching low income workers with appropriate mental health services have been shown to be inadequate."

The United Auto Workers is the first major union to achieve comprehensive nationwide psychiatric benefits for its members as a result of the bargaining process. Covering two and a half million workers and their dependents the UAW plan, which goes into effect on September 1st of this year, entitles each member to \$400 a year in out-patient benefits. Its emphasis upon treatment in the doctor's office or in day hospitals, community mental health centers or clinics; its coverage of the services of various members of the mental health team, including psychologists and social workers, and its use of group psychotherapy and family counselling embody the most enlightened and most eclectic principles of progressive mental health coverage. In implementing this contract in 77 cities, the

has been an exciting alliance of labor and mental health professional leadership in breaking out of antiquated molds and creating additional services in the core of the community.

And then we have the challenge of the poor. We seem to have just discovered them these past several years, but Albert Deutsch knew them and wrote feelingly about their deprivations for many, many years. His historical vignettes on the poor laws -- going back to a classic study of the Elizabethan Poor Law of 1601 -- can now be seen as pioneer attempts to deal with a great social problem. Sixteen years ago, he wrote of "abolishing that social disease we call poverty". He often talked to me about his great dream -- to write a history of the poor in America -- and it is tragic that his untimely death prevented its achievement.

Psychiatry has been slow in coming to grips with the poor, a somewhat ironic deficiency since the acknowledged father of modern psychiatry, Sigmund Freud, touched frequently upon the inability of his profession to reach out to the large masses of people who were impoverished. In 1919, for example, he wrote:

"One may reasonably expect that at some time or other the conscience of the community will awake and admonish it that the poor man has just as much right to help for his mind as he now has for the surgeon's means of saving his life; and that the neuroses menace the health of the people no less than tuberculosis, and can be left as little as the latter to the feeble handling of individuals."

In recent years, a number of epidemiological studies have demonstrated the high positive correlation between schizophrenia and poverty. There is a growing band of young Turks in the psychiatric profession which is putting its elders on notice that psychiatry must move out into the community or risk bankruptcy as an effective therapy.

"The poor neither know about us nor can they afford our expensive care", the young psychiatrist Robert Coles wrote recently. "And often we do not know about the poor and seem little concerned about getting to know them. There are the facts, plain to see but not so easy to change. Nevertheless, the medical profession and its several specialities will have to serve the large numbers who need them most and can afford them least."

In this iconoclastic era in which many of the ancient walls are tumbling down, we are discovering the emotionally disturbed child hidden away in a state mental hospital or pushed about from one agency to another in the community. We don't really have any firm estimate of how many emotionally disturbed children there are in this country, although there is a consensus that it may run as high as four million. Only 300,000 of these were seen in mental health clinics last year, most of them for diagnostic purposes and only the briefest of treatment. A study of the first year of Operation Head Start indicates that approximately 10% of the more than 600,000 children enrolled last summer were so emotionally disturbed that they were unable to benefit from the program.

As you in the social welfare field know, statistics like these tell only a small part of the story. At a conference on emotionally disturbed children in California recently, I listened to the case history of a boy who, between the ages of five and seven, had been buffeted about among 17 social agencies.

We are now launching the first national effort to do something about this frightful human and social wastage. As a result of legislation passed in 1965, the federal government has provided one million dollars over the coming two years to a Joint Commission on Mental Health of Children which will, hopefully, assess the size of the problem and come up with some mechanisms for attacking it.

Because of limitations of time, I have been able to touch upon just a few of the trends which are beginning to bring the care of the mentally ill within the spectrum of our communal concern. After living in the shadows for almost two centuries, some are walking in the sunshine for the first time, and the light is sometimes blinding. In this difficult transitional period, they need your help and your understanding. You

are deeply rooted in the social agencies of the community; your knowledge and your compassion are crucial in building the many bridges over which they can travel back to a new life.

We in the mental health field, and you in the social welfare field, have a common goal -- beautifully expressed by Albert Deutsch in one of his last newspaper columns:

"If I have frequently attacked conditions I regard as evil, it is only because I would like to see everyone get a chance at the wonderful variety of pleasing experiences that our marvellously rich society affords -- potentially. The basic tragedy of our time, it has seemed to me, is that we should tolerate so much misery, friction and unhappiness when there is a potential abundance that all could share in peace."